TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TASA, PC

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-17-2321-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
APRIL 3, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our Facility has been having difficulties with the above carrier in processing these authorized services which were denied for fee schedule adjustment."

Amount in Dispute: $15,059.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After further review of the bill our position of non-payment of the bill being submitted provider remains unchanged

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 11, 2017	Psychiatric Diagnostic Evaluation CPT Code 90791	$347.00	Not eligible for review
January 19, 2017	Office Visit CPT Code 99213	$156.00	
February 7, 2017	Functional Capacity Evaluation CPT Code 97750-FC	$856.00	
February 26, 2017	Unusual Travel (Eg, Transportation And Escort Of Patient) CPT Code 99082	$260.00	
February 27, 2017 February 28, 2017 March 1, 2017	Chronic Pain Management Program CPT Code 97799-CP (24 hours)	$3,960.00	
March 2, 2017 March 3, 2017 March 6, 2017 March 7, 2017 March 8, 2017 March 9, 2017 March 10, 2017 March 14, 2017	Chronic Pain Management Program CPT Code 97799-CP (56 hours)	$9,240.00	$5,600.00

March 6, 2017	Unusual Travel (Eg, Transportation And Escort Of Patient) CPT Code 99082	$240.00	$0.00
TOTAL		$15,059.00	$5,600.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.230, effective July 17, 2016 sets out the reimbursement guidelines for chronic pain management programs.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. 28 Texas Administrative Code §141.1 sets out the procedures for Requesting and Setting a Benefit Review Conference.
5. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
6. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 219-Based on extent of injury.
   - P6-Based on entitlement to benefits.
   - No explanation of benefits were submitted by either party for dates of service March 2, 2017 through March 14, 2017.

Issues

1. Does the medical fee dispute referenced above contain information/documentation to support that dates of service January 11, 2017 through March 1, 2017 contains unresolved issues of entitlement to benefits and extent of injury?
2. Did the requestor submit documentation to support that the entitlement to benefits and extent of injury issue was resolved prior to the submission of the dispute?
3. What is the appropriate dispute resolution process for resolving issue of entitlement to benefits and extent of injury?
4. Are dates of service January 11, 2017 through March 1, 2017 eligible for review?
5. What is the applicable rule for determining reimbursement for chronic pain management program rendered March 2, 2017 through March 14, 2017? Is the requestor entitled to additional reimbursement?
6. What is the applicable rule for determining reimbursement for CPT code 99082 rendered March 6, 2017? Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks resolution for CPT codes 90791, 99213, 97750-FC, 99082 and 97799-CP rendered January 11, 2017 through March 1, 2017. Review of the submitted documentation finds that the medical fee dispute referenced above contains unresolved issues of entitlement to benefits and extent of injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical billing process.

2. 28 Texas Administrative Code §133.305(b) requires that extent-of-injury/entitlement to benefits disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f) (3) (C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved extent-of-injury dispute for the claim. 28 Texas Administrative Code §133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute. The Division finds that the dispute contains unresolved issues of entitlement to benefits and extent of injury. As a result, the dispute is not eligible for review by MFDR until final adjudication of the Compensability issues.

3. The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of entitlement to benefits and extent of injury, including disputes or disagreements among the parties over whether the medical

services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1.

4. 28 Texas Administrative Code §133.307(f) (3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation ("Division"). The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals, on the Compensability dispute. The division finds that at this time, dates of service January 11, 2017 through March 1, 2017 are not eligible for review.

5. The requestor is seeking dispute resolution for a chronic pain management program rendered from March 2 through March 14, 2017. The requestor submitted copies of bills addressed to Gallagher Bassett that lists the same address as the bills for January 11, 2017 through March 1, 2017. The respondent did not dispute that they had not received the bills from March 2 through March 14, 2017. Neither party to the dispute submitted explanation of benefits for the disputed services; therefore, the disputed services will be reviewed per fee guideline.

   The fee guideline for chronic pain management services is found in 28 Texas Administrative Code §134.230.

   28 Texas Administrative Code §134.230(1) states "Accreditation by the CARF is recommended, but not required. (A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the maximum allowable reimbursement (MAR). (B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

   The requestor billed 97799-CP; therefore, the disputed program is non-CARF accredited and reimbursement shall be 80% of the MAR.

   28 Texas Administrative Code §134.230 (5) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs.

   (A) Program shall be billed and reimbursed using CPT code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited programs shall add "CA" as a second modifier.

   (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

   The requestor billed for 56 hours of non-CARF accredited chronic pain management program. Based upon 28 Texas Administrative Code §134.230 (1) and (5), 80% of $125.00 = $100.00. $100.00 X 56 hours = $5,600.00. The respondent paid $0.00. The requestor is due the difference between the MAR and amount paid of $5,600.00.

6. The requestor is seeking dispute resolution for CPT code 99082 rendered on March 6, 2017. The requestor submitted copies of a bills addressed to Gallagher Bassett that lists the same address as the bills for January 11, 2017 through March 1, 2017. The respondent did not dispute that they had not received the bills from March 6, 2017. Neither party to the dispute submitted explanation of benefits for the disputed services; therefore, the disputed services will be reviewed per fee guideline.

   The fee guideline for CPT code 99082 is found in 28 Texas Administrative Code §134.203.

   28 Texas Administrative Code §134.203(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers…"

   28 Texas Administrative Code §134.203(f) states "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

CPT code 99082 is not priced by Medicare; therefore, 28 Texas Administrative Code §134.203 (f) applies. 28 Texas Administrative Code §134.1, requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." Review of the submitted documentation finds that the requestor's documentation does not discuss, demonstrate or justify the amount of $240.00 would be a fair and reasonable rate of reimbursement. As a result payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $5,600.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $5,600.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		7/28/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812